



UnitedHealth Group™

May 27, 2010

Commissioner David Morales
Division of Health Care Finance and Policy
Two Boylston Street, 5th floor
Boston, MA 02116
Sent by e-mail to: corine.peach@state.ma.us.

Re: Comments on Proposed regulation 114.CMR subparts 21.01 through
21.06, dated April 15, 2010

Dear Commissioner Morales:

On behalf of UnitedHealthcare, Ovations, Inc., Optum Health, Inc., and UnitedHealthOne, (hereafter "UnitedHealth Group") I respectfully submit the following comments on the proposed regulation defining the state's All Payer Claims Database. In the state of Massachusetts, collectively, our companies process claims or provide health insurance products for approximately 200,000 Massachusetts residents.

In addition to our specific comments below, we would like to make a general comment about the nature of the data we collect for the purposes of paying health care claims. As a national company, we have built our data systems to capture and process the information we need to pay claims. Paying claims is a core business function. We also build our systems to comply with existing state and federal laws that restrict the types of data we collect, such as HIPAA and comparable state laws.

We recognize and in fact agree with the State of Massachusetts that the data generated to pay claims can also be a rich source of information about what is working, and what is not working, within our health care system. We therefore support the concept of Massachusetts wanting to collect this data for public health and health care oversight activities, and applaud the state's desire to make some of the collected data available for use by the public.

Our concern, however, is that despite the fact that payer administrative claims data is a rich source of some types of information, it is not a source at all for other types of information because (1) a health plan is restricted in the amount of

information it collects or retains; (2) a health plan is not required to collect the information sought, and therefore is a poor source for that information.

To elaborate, under the Health Insurance Portability and Accountability Act (HIPAA), a health plan is allowed to collect patient identifiable information that is the "minimum necessary" (45 CFR 164.514) for the payer's payment obligations and the payer's health care operations. So, if to render a payment pursuant to a particular provider contract, we need only know the billing provider, we do not necessarily retain information about the servicing provider in our system. Thus, if a regulation such as that proposed by Massachusetts requests us to supply data that we have not captured in our systems because it is not the minimum necessary, then we can predict in advance that compliance with the regulations will be slow, overly burdensome and expensive, as systems have to be re-engineered to capture information on a go forward basis; retrospective information already securely disposed of will not be able to be reported, etc.

Race, ethnicity, language preference, and other information important to measure and report on disparities in health care pose a similar, but more acute problem. A health plan does not normally need to know a member's race, ethnicity, religion or language preference in order to pay a claim. Standard claims forms do not require that this information be supplied. And, it is certainly possible to imagine in different circumstances offense being taken by a health plan's attempt to collect race, ethnicity and similar information without a legal requirement that it be collected.

We supply these two examples as a preamble to help illustrate the conundrum presented by state data collection as described in the proposed regulations: on the one hand, we want to cooperate with the state's important goals to oversee and improve healthcare delivery; on the other hand, our ability to do so is hampered by the intentionally limited nature of our data systems, built to comply with national minimums for protection of patient privacy and to efficiently collect and process only that information that we need to complete our core functions as a health plan.

Therefore, we submit, the state's proposed regulations should be appropriately redrafted to recognize the actual limits of health plan data systems. We look forward to collaborating with the state in other ways to help develop ways that Massachusetts might measure, report on, and then reduce, disparities in health care.

Below are our specific comments on the proposed regulations.

Comment 1: UnitedHealth Group recognizes that there remain possible questions about the jurisdiction of the Division over a self-insured employer health benefits plan (as defined in ERISA) and requests that the Division clarify the definition of "Payer" in sec. 20.02 to leave less room for interpretation of this

jurisdictional question and to eliminate the phrase "to the extent allowable under federal law". More clarity of this definition would help data suppliers ensure their ongoing compliance with law and regulations. UnitedHealth Group will comply with any lawful requirement imposed on third party administration licenses it has in Massachusetts, but the Division must recognize that the manner in which federal law and this regulation interact is subject to the interpretation of the ERISA plans serviced by that TPA license. Furthermore, for ERISA self-funded plans, the claims data is controlled by the plan fiduciaries and not the TPA, the TPA is merely a custodian pursuant to a business associate agreement. The TPAs use of the data, therefore, is limited as set forth in the business associate agreement. The broad definition of "payer" in the draft regulations, coupled with the "to the extent allowable" language creates, at the very least, ambiguity and confusion for a TPA about which rules apply to its handling of data from a self insured ERISA plan.

Comment 2: UnitedHealth Group recognizes the value a state, and its payers, share in a detailed understanding of whether the same quality and value in healthcare is available equally to all residents, regardless of race, ethnicity or language ("REL data"). Unfortunately, UnitedHealth Group lacks the REL data proposed to be collected under the proposed regulation, and will not have such data for the foreseeable future. UnitedHealth Group has never collected such data as it was unnecessary to adjudicate claims or for other health care operations. Furthermore, the collection of REL data is certainly sensitive, and UnitedHealth Group is unclear whether collection of it for payment of health care claims would be lawful as we have not investigated this issue. Therefore, UnitedHealth Group requests that the requirement to submit "race, ethnicity and language information" be deleted as a required data element until such time as the State of Massachusetts requires health care providers to report that information about their patients in order to be paid by a payer, or until such time as the State of Massachusetts requires members and subscribers to supply that information in order to be enrolled for coverage. In the meantime, UnitedHealth Group would welcome the opportunity to work with the State of Massachusetts on collaboratively developing other methods of identifying and addressing healthcare disparities.

Comment 3: UnitedHealth Group requests confirmation that supplying data indicating the presence of a behavioral health, mental health, substance abuse, or chemical dependency benefit as it relates to a particular member would not be disclosing sensitive information under State law, e.g. Mass. Gen. Laws ch. 175 sec. 108E, and similar Massachusetts laws.

Comment 4: Under sec. 21.03(1)c, the proposed regulation requires monthly data submissions. While UnitedHealth Group understands that in other states, monthly submission is the norm, we also believe, based on the advice of health informaticists and our experience with similar projects conducted on voluntary bases in other states, that for the analytic work that might be undertaken by

Massachusetts, a monthly submission is too frequent. For example, health claims can have a 90 day run out period. As such, a quarterly submission should accurately capture the necessary information while at the same time significantly lowering the cost of compliance for data submitters and the data processing costs of the state. UnitedHealth Group respectfully requests that the frequency of data submission be changed to a quarterly requirement.

Comment 5: UnitedHealth Group understands the state's desire to collect the information briefly described in section 21.03(2). However, in light of the passage of the Patient Protection and Affordable Care Act of 2010, and that law's requirement that the National Association of Insurance Commissioners develop a standard definition of medical loss ratio for compliance purposes of that law, UnitedHealth Group respectfully submits that the items specified in 21.03(2)b and d be omitted from the final regulation until such time as those terms can be made consistent with the definition to be developed by the NAIC. The Act requires the NAIC definition to be final by July of 2010. Given, however, that no definition has yet been published as of the date of this letter, UnitedHealth Group requests that in any event the final regulations use the same definition of MLR as that eventually adopted by NAIC.

Comment 6: Section 21.03(2)f as proposed requires that data submitters supply information on their payment methods. This highly confidential and sensitive information, could implicate proprietary information negotiated on behalf of consumers with business partners, hospitals, physicians, groups, and pharmacies of Massachusetts. UnitedHealth Group agrees that this data can be valuable to create information for the State on an aggregated basis about cost-drivers of health care in Massachusetts, or to create aggregated educational information for consumers about relative value in health care (through resource use measurement, for example). Nevertheless, UnitedHealth Group does not believe that this information in its raw form should be public because its disclosure could actually drive up health costs by disclosing discount arrangements. Accordingly, UnitedHealth Group respectfully requests that the information required to be submitted under section 21.03(2)f should remain non-public information, even if the state of Massachusetts uses that information to create research, analysis, and other information for the public's benefit.

Comment 7: UnitedHealth Group respectfully requests that section 21.03(4)b. be revised to include a clear definition of "medical products", which is not a term defined in section 20.02. The current regulations, which the proposed regulation would replace, provides an excellent starting point, but UnitedHealth Group also notes that among the collectivity of states with all payer claims databases, a standard is emerging regarding what types of health insurance products should be included in reporting. UnitedHealth Group requests that Massachusetts adopt that emerging, standard definition, which is described below:

(c) Carriers shall not be required to submit claims for stand-alone insurance policies that cover only one or more of the types of services listed in 129 CMR 2.05(5)(c)1 through 12.; however claims for these types of services shall be included in the medical claims file submission if they are covered by a comprehensive medical insurance policy:

1. Specific disease;
2. Accident;
3. Injury;
4. Hospital indemnity;
5. Disability;
6. Long-term care;
7. Vision coverage;
8. Durable medical equipment;
9. Workers compensation; [see e.g. OAR 409-025-0110(1)(c)
10. Credit; [Id.]
11. Medicare supplement; Id. See also Co Stat Rev. 10-16-102 (2009), subpart (21) to (22.5)
12. Student Liability; [see e.g. Maine regulations, Ch. 243, sec 90-050, part 2(9)(a).

UnitedHealth Group also notes that the inclusion of data from a Medicare Supplemental policy may be methodologically inappropriate, given that such claims are predominantly secondary in nature and often cover items such as coinsurance and co-payments.

Comment 8: UnitedHealth Group requests that the scope of the claim submission requirements be clarified in Sections 21.02 and 21.03. We ask the Department to clarify whether it intends to require reporting only by entities licensed in the State and/or for policies issued in the State? The current language is susceptible to conflicting interpretations.

UnitedHealth Group also requests that the provisions of 21.03(4)b 1 be narrowed to apply only to residents of Massachusetts. Given Massachusetts' proximity to other states who exercise their own police powers over their residents, UnitedHealth Group wants to ensure that required reporting will also comply with the rights of non-Massachusetts residents.

In addition, UnitedHealth Group believes that it would be appropriate to include a minimum number of covered lives as a reporting threshold in Massachusetts. Specifically, Massachusetts already requires some separate claims data set submissions to the Health Care Quality & Cost Council under 129 CMR 2.00 to 2.13. Those requirements exempt entities with less than 200 covered lives in the State of Massachusetts from reporting. We would encourage the state to increase the threshold to carriers with more than 2,000 covered Massachusetts residents; 2,000 is the average by our calculation of the range of similar

requirements from other states with similar all payer claims databases. We believe that such a threshold will help to ensure that the state of Massachusetts obtains more valid data, while minimizing the administrative costs to carriers with incidental business in Massachusetts.

Comment 9: Section 21.03(4)d describes the provider listings required to be supplied. UnitedHealth Group has several questions and comments. First, the proposed provider file assumes that a payer collects the same data on in-network providers as it does on out-of-network providers. Through our network contracts, we can, and do establish claims submission rules that ensure we capture the information sought by the state, which we also seek for payment purposes. However, as to non-network providers, we lack contracts with non-network providers and therefore, we lack the means and ability to enforce such rules about required data from out-of-network providers. For example, UnitedHealth Group would likely not have, concerning an out-of-network provider, such fields as PCP Indicator, PPO Indicator, network ID, begin date, or end date. Even for in-network providers, we may not have fields such as P4P Flag or Accepting New Patients. Second, this section also appears to require health plans to report to the State of Massachusetts about care supplied by providers and facilities in others states. We are uncertain about our ability to report to the State of Massachusetts information about healthcare supplied to Massachusetts residents by providers in other states Therefore, UnitedHealth Group respectfully requests that this subsection be clarified to require reporting of the specified elements only on contracted providers within UnitedHealth Group's network and within Massachusetts.

Comment 10: UnitedHealth Group requests that Schedule A be amended to reconcile its content to the final regulations issued by the Division. Specifically, UnitedHealth Group requests that the Division not require the first data submission under this new regulation until at least 120 days from the effective date of the final rule to ensure adequate time to program and test files. Payers not currently submitting data to the Division via the Health Care Quality & Cost Council under 129 CMR 2.00 to 2.13 will need more time -- at least 180 days in our estimation-- to make system changes to begin reporting this data. Finally, we request that future changes to Schedule A be made either only through further rulemaking, or, at the very least, with 120 days advance notice so that data submitters have reasonable time to plan for compliance.

Comment 11: UnitedHealth Group also would like to take this opportunity to briefly comment on the proposed public release regulations. First, we agree with the comments of the Massachusetts Association of Health Plans that the public release regulations must impose firm, but fair, penalties for misuse or abuse of data that is released publicly. UnitedHealth Group also believes that the public release rules must eventually support and promote the greater transparency and understanding of what is working well and poorly in health care, and recognize that academic researchers, non-profits, and health plans themselves all have

important roles to play in using publicly released data and making analytic results meaning for patients, providers, and in support of changes to the delivery system.

UnitedHealthcare, Ovations, Inc., Optum Health, and UnitedHealthOne all appreciate the opportunity to submit these comments, and on behalf of my colleagues, I look forward to working with you further to implement this all payer claims database system efficiently, effectively, and collaboratively.

Sincerely,

A handwritten signature in black ink, appearing to read "Jason C. Martiesian", with a stylized flourish at the end.

Jason C. Martiesian
Vice President, State Government Affairs